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ORIGINAL ARTICLES

THE IMPORTANCE OF EARLY DIAGNOSIS IN UROLOGY*

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The importance of early discovery of urologic pathology cannot be overemphasized. Urology, as it is practiced today, offers such diagnostic methods of precision that practically in all cases the underlying pathology can be ascertained with reasonable certainty. However, in spite of this fact, many patients are deprived of the benefit of these diagnostic means and have frequently been subjected to operative procedures without symptomatic relief. Carson[1] stated significantly that in over 1200 autopsies performed at the University Hospital, Baltimore, the most frequent site for clinically undiagnosed lesions was the genito-urinary tract.

The cause of failure to diagnose disease or anomaly of the urinary tract is principally due to the fact that the indications for a urologic survey are frequently not recognized; on the other hand, not a few physicians still look upon cystoscopy with disfavor and are quite unwilling to subject their patients to a supposedly dreadful procedure.

The first subjective symptom of urinary disease, in the majority of cases, is disturbance in the act of micturition. This disturbance is manifested by increased frequency, burning, urgency, dysuria, tenesmus and incontinence, singly or in various combinations. When a patient presents himself with a definite history of such disturbances, obviously, the physician's attention immediately centers about the genito-urinary tract. However, it is important to note that such subjective evidence of urinary tract pathology is not infrequently lacking and instead, indefinite pains or aches, or certain abnormal findings in the urine, such as blood or pus, are the only diagnostic guides available. It is in this type of cases that usual errors in diagnosis are made and the underlying pathological process is allowed to progress.

The purpose of this paper is, therefore, to call attention to a large number of cases in which disturbances in the act of micturition are either absent or slight and the outstanding symptom is pain—not directly referable to urinary tract, hematuria or pyuria.

Pain: Pain due to urinary disease is variable in character. When it begins in the lumbar region and radiates forward and downward to the inner side of the thigh, or the testis, one quite naturally suspects the urinary tract as the source of trouble; but more often than not, pain of urinary disease is not so well defined, and the variability of its location, intensity and duration, particularly when associated with certain gastro-intestinal symptoms, is often confusing. Yet, it is common knowledge that abdominal pain associated with distress after meals, nausea, vomiting or gaseous eructations, is not always due to disease of the digestive tract, and that not infrequently, these symptoms are reflex manifestations of a pathological lesion in the upper urinary tract. As the nerve supply of the kidney, the ureter and the gastro-intestinal tract has a sympathetic derivation, the occurrence of these reflex phenomena can readily be explained. Consequently, a correct diagnosis in the absence of a definite localization of pain, can only be arrived at by a process of elimination. In a case presenting vague abdominal pains and digestive symptoms, a study of the gastro-intestinal tract and the gall bladder would be the first order of procedure; however, in the absence of positive findings, it should be considered good judgment to subject the patient to a complete urological examination.

A statistical study from various clinics shows that urinary disease is frequently mistaken for surgical disease of the abdomen, particularly chronic appendicitis. Lowsley and Twinem[2] reported 84 cases which were treated surgically or medically for pathological conditions supposedly other than those of the urinary tract without relief of symptoms; subsequent urologic study showed all of them suffering from definite diseases and anomalies of the

*Read before the Pawtucket Medical Association, May 17, 1934.

kidney or ureter. Of these 84 cases, 31 patients were previously operated upon for chronic appendicitis, 3 patients had appendectomy and cholecystectomy, 5 patients had salpingectomy and oophorectomy, 10 patients were advised to have the appendix removed but refused and 34 patients were treated medically. All of these patients were subsequently cured or relieved by appropriate urologic procedures. Beck[1] of Baltimore reported 284 urologic cases in which the major symptoms were referable to other parts of the body, the gastro-intestinal symptoms predominating. In this series, 207 operations were performed prior to urologic study; of this number, 137 were abdominal and pelvic operations.

The experience of these investigators and of many others has conclusively demonstrated the value of urologic study in all doubtful cases.

There is, however, a counterpart to this discussion and that is the possibility of mistaking other surgical diseases of the abdomen for disease of the urinary tract. I hope we are all aware of the dangerous possibilities of appendicitis; at times, it is extremely difficult to differentiate between appendicitis and ureteral stricture or calculus. Also, it is possible to mistake intestinal obstruction, when the pain is colicky in nature, to stone in the urinary tract.

Hematuria: Hematuria, gross or microscopic, is a danger signal. This fact should be forcefully driven home whenever there is a discussion relative to urologic diagnosis. Although the profession as a whole is cognizant of the potential dangers of this symptom, unfortunately, not a few practitioners still revert to pre-cystoscopic days and treat their patients with urinary antiseptics and when the blood temporarily disappears from the urine, as it usually does, congratulate themselves for the efficacy of such treatment. We believe the painlessness of most hematurias and their character of intermittency have been the two principal causes of complacency on the part of both the patient and the physician.

The source of bleeding can often be approximately determined by correlating the accompanying signs and symptoms. Systemic causes of hematuria, such as hemophilia, purpura hemorrhagica, leukemia, Hodgkin's Disease, or hematuria due to high protein diet, physical exertion and ingestion of drugs should be kept in mind. Blood in the urine due to acute infections of the lower urogenital tract, such as gonorrhea and its complications, or that due to prostatic hypertrophy or carcinoma, is usually associated with disturbances of micturition and can easily be accounted for. Hematuria when accompanied by colicky pains in the lumbar region or abdomen usually calls attention to the kidney or ureter. When bleeding occurs at the beginning of urination, it indicates a urethral origin. Terminal hematuria may mean acute inflammation, enlarged prostate or new growth at or about the vesical orifice.

As a preliminary procedure, the three glass test or preferably the Wolbarst five glass catheter test will give valuable information as to the source of bleeding provided it is not profuse. When bleeding appears to be in the anterior urethra, the urethroscope, and when in the posterior urethra, the cystourethroscope, will determine the character of the underlying lesion. In acute inflammatory conditions, however, neither instrument should be used. When the urinary tract proper is suspected as the source of hematuria, a preliminary X-ray examination should be made, followed by cystoscopy, ureteral catheterization, differential function tests, and finally pyelography and ureterography. The cystoscopic examination should be carried out, if possible, before the bleeding ceases, as it would be easier to determine its location, particularly in those cases where the underlying pathological lesion is not pronounced.

With the employment of modern instruments, it is seldom that the urologist is at a loss as to the actual source of bleeding. Thomas[3] investigated 430 patients with hematuria, not due to gonorrhea or trauma, and found that in only 2.5 per cent the cause could not be determined. It is not surprising, therefore, that one hears less and less about "essential hematuria."

The pathological lesions of the urinary tract causing hematuria are many and varied; the most common findings, however, are tumor, calculus and tuberculosis.

Chute[4] analyzed 100 cases of hematuria in 1920 and found 64 per cent of them due to a growth in the prostate, bladder or the kidney. Investigating another 100 cases in 1924, he found that 14 per cent of the bleeding originated in the prostate, 46 per cent in the bladder and 40 per cent in the kidney. In this series, malignancy was responsible for 30 per cent of the prostatic, 75 per cent of the vesical and 12 per cent of the renal bleeding. This

investigation confirms the common observation that the most frequent site for carcinoma is first the bladder, second the prostate and third the kidney.

It is estimated that about 15% of all prostates causing urinary obstruction are malignant. Therefore, a routine rectal examination in all male patients over fifty years of age will contribute in large measure to the early discovery of this serious lesion.

In 902 epithelial tumors of the bladder studied recently by the Committee on Carcinoma Registry of the American Urological Association,[5] hematuria was the initial symptom in 63.52 per cent. As not a small number of bladder carcinomata begin in the form of papillomata, the early detection of blood in the urine and cystoscopy, followed by simple fulguration of the tumor, will materially enhance the chances for permanent cure.

Eisendrath and Rolnick[6] state that hematuria is the initial symptom in over 60 per cent of renal tumors, except in children in whom a tumor mass is the most common initial finding. In the absence of other pathological lesions of the urinary tract, the possibility of kidney tumor should be considered and pyelographic studies made before metastasis takes place and a palpable mass is present.

Pyuria: Pyuria or pus in the urine is an important finding. As it is frequently the only symptom, the urine of every patient presenting himself for a general physical examination should be carefully examined.

Pyuria may be due to a primary infection in the urinary tract or it may be secondary to calculus, tumor, foreign body, stricture, obstruction at the bladder neck or retention of neuromuscular origin. Often one's attention is directed to the source of pus by certain associated factors. For example, a history of recent exposure and presence of discharge at the meatus as a rule means a urethral infection. The nature of this infection should be determined by a microscopic examination of the stained specimen, as, it is needless to say, a urethral discharge may not be gonorrheal.

In pyuria as in hematuria the three glass test or the five glass catheter test is of considerable value. In the presence of chronic infections of the urethra and its adnexa, endoscopic examinations will frequently reveal pathology in and around the verumontanum. If the origin of pus is in the urinary tract proper, cystoscopy, supplemented by ureteral catheterization, functional tests, pyelography and ureterography will establish the diagnosis.

In the female, the urine should be obtained by catheterization, as voided urine being frequently mixed with discharges from the genital tract, cannot be relied upon.

Pyuria when accompanied by increased frequency, burning, dysuria, or urgency is frequently attributed to a simple cystitis and the patient is often treated for months with urinary antiseptics and bladder lavage. There is no justification for this presumption. We have already mentioned the multiplicity of lesions in the bladder, ureter and kidney frequently causing a secondary infection of the bladder, with the production of pus and disturbance of urination. Furthermore, a simple cystitis is an uncommon occurrence. By far the large proportion of cases of cystitis are secondary to a descending infection from the upper urinary tract. If this fact is borne in mind, there will be less delay in subjecting the patient to a cystoscopic examination.

The possibility of renal tuberculosis in the presence of pus or blood and persistently progressive frequency or dysuria, particularly in young adults, should be strongly suspected. Occasionally, pyuria or hematuria is the only presenting symptom. Also the urine from a case of renal tuberculosis is usually acid in reaction, sterile on culture and contains tubercle bacilli in addition to pus or blood. One must also remember that urinary tuberculosis is secondary to tuberculous foci elsewhere in the body, and that a tuberculous cystitis is always secondary to renal tuberculosis except in a very small number of cases where bladder involvement follows an ascending infection from genital tuberculosis. Here again the final diagnosis is arrived at by cystoscopy, ureteral catheterization, functional tests and pyelo-ureterography.

Pyuria and hematuria require special emphasis in children. Contrary to a general impression, practically all the urological lesions found in adults up to the age of fifty are also found in children. Sixty-two children with urinary symptoms studied by Thomas and Birdsall[7] showed a variety of pathological conditions, such as pyelitis, pyelonephritis, hydronephrosis, pyonephrosis, calculi, bladder diverticula and enlarged verumontanum with granulations. Bugbee and Woolstein[8] reviewed 4,903 necropsies in infants in the Babies' Hospital in New York and found 117 anomalies of the urinary tract, in almost all of them there was interference with the urinary drainage.

Pyelitis is the most common urological finding in children, girls being particularly susceptible to this type of infection. The treatment of pyelitis is admittedly medical, practically all cases clear up with increased intake of fluids, alkalies and urinary antiseptics. However, if a case of pyelitis does not clear up under this regimen, the possibility of an associated lesion should be seriously considered. These lesions are either obstructive, such as stricture, calculus or congenital valves of the urethra, or destructive, such as pyelonephritis, phyonephrosis or tuberculosis. The timely discovery of these lesions can only be made by carrying out in these little patients precisely the same urologic investigation as in the adult. Under general anesthesia and with the employment of instruments especially designed for children, these investigations can be carried out satisfactorily even in very young infants.

Enuresis in children not infrequently is due to a pathological lesion in the urinary tract. Thomas and Birdsall[7] subjected 12 patients with nocturnal enuresis to urologic study. In two cases, they found such lesions as hydronephrosis, hydroureter and diverticulum of the bladder, nine cases showed hypertrophy of the verumontanum with granulations and one case showed a polypoid growth of the verumontanum. Campbell[9] made complete urological studies in 249 children, four years of age or older; previously the diagnosis of enuresis was made in all of them and various modes of therapy were employed without avail; it is illuminating to note that urinary tract pathology accounted for the symptoms in 60 per cent of this series. Consequently in cases of enuresis with abnormal findings in the urine, also in cases that do not respond to recognized therapeutic measures, a complete urologic study is likely to reveal a pathological lesion.

Summary

Urology with the aid of the modern cystoscope and the X-ray offers an exceptional opportunity for early diagnosis.

Pain not directly referable to urinary tract may originate from a pathological lesion in that tract, and calls for urologic study, particularly before abdominal operations.

Hematuria and pyuria are warning signals and should immediately be investigated by all the diagnostic procedures at our disposal when such serious diseases as stone, cancer and tuberculosis are within the sphere of curability.

The same diagnostic procedures are applicable in children as in adults and should fully be utilized, particularly in cases of cystitis, pyelitis and enuresis when accepted therapeutic measures prove unsuccessful.

The following cases illustrate briefly some of the salient points brought out in this paper:

Case 1: J. B., male, age 22. Complained of increased frequency, dysuria and occasional pain in the right lumbar region for the past three years. Had noticed blood in his urine four times during this period. Had been treated for cystitis on and off. When first seen, he was voiding every 15-20 minutes and suffering great pain; urine was cloudy and loaded with pus and blood cells; considerable tenderness present over the right costovertebral angle. Urologic study showed numerous dense shadows in the right kidney and a large circular shadow about one inch in diameter in the bladder. The bladder stone was removed by suprapubic cystotomy and right nephrectomy done 26 days later.

This was a badly neglected case and was treated for simple cystitis without the benefit of a urological examination.

Case 2: N. C., male, age 27. Contracted gonorrhea five years previously. Had been treated by urethral injections and prostatic massage, on and off, up to six months ago. Worked every day and felt well. Wanted to know if it was all right for him to marry.

Examination showed three glass test uniformly cloudy. Rectal examination revealed a small prostate with scattered areas of fibrosis. Prostatic fluid showed 10-12 W.B.C. per H.P.F. A No. 28 F. sound introduced without difficulty. Cystoscopy showed purulent urine coming in jets from the right ureteric orifice. Pyelography revealed a non-functioning calculous pyonephrosis on the right side.

A painless pyuria was the only symptom in this case. Also, this case shows the importance of detecting upper urinary tract pathology in the presence of chronic gonorrhea or a history of gonorrhea.

Case 3: M. M., female, age 30. Complained of palpitation and occasional pain in the epigastrium and left chest, also loss of appetite and strength for the past five years. Medicines prescribed by her doctor did not help. Has had no urinary symptoms. The examination of the chest was negative. There was slight tenderness over the left costo-vertebral

angle. Urine contained numerous pus and blood cells. Complete urological examination showed a normal kidney and ureter on the right side and a calculous pyonephrosis on the left. Nephrectomy was followed by complete recovery.

In this case, the symptoms were referred to parts other than the urinary tract.

CASE 4: S. D., male, age 42. Complained of weakness. Was under treatment at the Out-Patient Department for late syphilis. Examination of the urine showed numerous pus cells. Plain X-ray examination revealed a large branching calculus and two smaller calculi over the right kidney region. Pyelography completed the diagnosis of right calculous pyonephrosis which called for nephrectomy. This was carried out after a preliminary rest and tonic treatment.

This case also shows an extensive destruction of the kidney manifested by a painless pyuria.

CASE 5: R. T., female, age 33. Has had pain in the abdomen for six years. Pain always started on the left side and radiated forward to the entire abdomen. These attacks occurred about twice a month, were always accompanied by belching, nausea and vomiting, lasted from one to several hours and left her weak for three to four days. Has had no urinary symptoms. Was treated for "stomach trouble" by her doctor. The appendix was removed four years ago on the advice of an internist, the wound became infected and a ventral hernia resulted. However, appendectomy did not relieve her symptoms. Examination showed moderate tenderness over the left costo-vertebral angle. The urine was cloudy and showed numerous pus cells. A complete urological examination showed a normal kidney on the right side and a pyonephrosis with greatly diminished function on the left. Left nephrectomy resulted in complete cure.

In this case, the predominence of gastric symptoms was responsible for a mistaken diagnosis.

CASE 6: A. R., male, age 42. Had a severe attack of pain in the right lumbar region which ceased spontaneously at the end of one hour. On noticing blood in his urine, he called the family physician, who referred him for urologic study. Past history was negative except that he had an occasional dull ache in the back for about a year. Physical examination was essentially negative. Urine showed microscopic blood. Cystoscopy revealed a normal bladder. Phenolsulphonephthalein appeared in four minutes from the left side; there was no evidence of the dye in fifteen minutes from the right side. Pyelography showed a normal kidney on the left side and a very large hydronephrotic sac on the right.

This case illustrates the value of subjecting every patient with an initial attack of pain or hematuria to a complete urological examination, as one is unable to determine the extent of pathology by the severity or duration of the symptoms alone.

CASE 7: M. V., female, age 24. Complained of increased frequency and dysuria. A short course of bladder lavage did not relieve her symptoms, whereupon she was referred for cystoscopic examination by the attending physician. Urine showed microscopic pus and blood. Cystoscopic examination revealed a benign-looking cyst, the size of a small egg and having a short and broad pedicle, situated immediately below the right ureteric orifice and impinging upon the bladder neck. Both ureters were catheterized easily. Pyelography showed normal pelves and calices on both sides. This cystic mass was fulgurated three times at twelve-day intervals and disappeared completely with cessation of all her symptoms.

This case proves the value of cystoscopy in women with bladder symptoms who do not promptly respond to ordinary treatment.

CASE 8: V. L., female, age 9. This patient has been in the habit of wetting her bed since she was five years old. During the past year, she had marked frequency of urination and also wet herself during the day. Mother consulted two doctors who told her that she will be all right as she grows older. On noticing blood stains on patient's underwear, she consulted another physician, who promptly referred her for cystoscopy. Examination of the urine showed a large amount of pus. After a few preliminary bladder irrigations and administration of an antiseptic, her symptoms somewhat subsided and she was subjected to a complete urological examination. 1/12 gr. of morphine sulphate was given subcutaneously a half hour before the examination, this was followed in 20 minutes by instillation of 10 cc of 2 per cent novocain into the bladder. Cystoscopy revealed a chronically inflamed bladder. Pyelography showed no pathology in the upper urinary tract. Subsequent treatment for cystitis resulted in complete recovery.

I present this case, first, because this child went through all the steps of the examination without a

complaint, and second, because a diagnosis of enuresis was made by two physicians without an examination of the urine.

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SOME MEDICAL ASPECTS IN THE TREATMENT OF PULMONARY TUBERCULOSIS*

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A great clinician once said, "The worst that could happen to a consumptive, is to become tuberculous." When we see the number of patients with advanced tuberculosis presenting themselves for treatment, we wonder if such a statement did not bear some measure of truth even to-day. Every hopelessly advanced case was at some time during the course of his disease, eligible for curative treatment. The most outstanding and often little known cures occur in early cases. Fortunately some of them heal spontaneously and, still more fortunately, some are diagnosed in the minimal stage of the disease, so that effective treatment is promptly instituted. It seems, therefore, that the best treatment, as far as the patient is concerned, is to diagnose and treat his tuberculosis at the earliest possible moment.

The diagnosis of tuberculosis is the physicians' responsibility and it is our duty to awaken in the patients and parents their sense of responsibility in seeking medical advice at the first indication of ill health. We cannot, with our present knowledge, hastily pass judgment as to whether disease is present or absent by a mere cursory physical examination or by deducing that tuberculosis does not exist because the individual looks healthy and presents no positive physical signs. The exclusion of early tuberculosis is not always a simple matter and since there are no symptoms, subjectively or objectively, pathognomonic of early tuberculosis, we must make full use of all the diagnostic measures at our disposal.

The history must be painstakingly recorded, inquiring carefully for a long forgotten hemoptysis, an antecedent pleurisy with effusion, the presence of tuberculosis in some members of the family probably long since dead, continued exposure to tuberculosis in the family or among associates or friends. An unusually prolonged attack of so-called "influenza" sometimes turns out to be a chronic pulmonary tuberculosis. These facts will often give us valuable information as to the probable duration of the disease.

The symptoms, languor, malaise, easy fatigue, loss of weight, nervousness and irritability are not peculiar to tuberculosis alone, but their presence warrants a thorough consideration of the disease as a possible causative factor. When the localizing symptoms of cough, expectoration, hemoptysis, pain in the chest and persistent fever become associated with the more general complaints, the disease is probably passed the early stage.

Physical examination in early tuberculosis is most disappointing. In a large percentage of cases, abnormal physical signs are absent and the realization of this fact has been a severe jolt to our diagnostic acumen. It is, nevertheless, true, that in tuberculosis, an extensive involvement may be present in the lungs which is non-detectable and inaudible by physical examination. The presence of coarse rales or amphoric breathing usually indicates that the disease has passed the incipient stage.

A careful examination of the sputum by concentration or animal inoculation is of course essential. A negative sputum is generally the rule in early tuberculosis. A positive sputum invariably means

*Read before the Providence Medical Association on March 5, 1934.

that tissue destruction and probably cavity formation has taken place.

No examination for tuberculosis, no matter how thorough, is complete without a carefully taken and intelligently interpreted X-ray of the chest. Consideration of the X-ray alone, however, without the other factors often leads us into serious pitfalls. The X-ray tells us the type of lesion we are dealing with; it points out its exact location and extent. Intelligent therapy cannot be carried out without this knowledge. By means of serial X-ray studies we are able to visualize the progress of the lesion and to ascertain the effectiveness of treatment. Many patients with pronounced clinical improvement, show, on X-ray, a definitely progressive lesion. On the other hand, many individuals are diagnosed as tuberculous clinically, and prove to be non-tuberculous after X-ray study.

If these procedures are diligently carried out in every case, diagnostic errors will certainly be greatly minimized and a larger number of patients will be cured.

After the diagnosis has been made, the physician then prepares for the disposal of the case. In many has been found, the patient is sent away to an in- instances it is literally just that. Once tuberculosis stitution and the incident becomes a closed book. As a matter of fact when tuberculosis is diagnosed, the book has just been opened. The present day management and treatment of tuberculosis should be within the scope of the practicing physician and the extent of his interest in this disease, from every angle, will largely determine the ultimate success of all efforts now being made to stamp out tuberculosis. We were formerly interested in the prevention of the disease; we are now concerned with its eradication as well.

From the standpoint of therapy, prolonged discussion is possible under any of the various methods. The following remarks are intended to briefly point out some of the more practical aspects.

The sanatorium has been responsible, to a very large degree, for the drop in the mortality rate from tuberculosis. Originally intended for the care of early cases, the experience of those in charge of these institutions has been that only a small percentage of their population is admitted in the early stages of the disease. Sanatorium physicians often wonder, therefore, why their patients are not sent to them sooner, so that therapy might be more efficaciously given. It is true that many cases are advanced when first examined, but, on the other hand, some of the early stage cases rest in bed at home while awaiting a vacancy in the sanatorium. When they are called, some of them feel so much improved that they would rather continue the cure where it was started. This does not mean that all cases get well at home and hence the sanatorium is unnecessary. By far the large majority of patients need institutional care and the institution can only accommodate as many as its capacity will allow. Positive sputum cases, advanced cases, and minimal cases with poor home facilities do better in the sanatorium than anywhere else. The selection of cases suitable for home treatment must be made with great caution. The patient with a minimal or moderately advanced lesion without positive sputum, who is intelligent, co-operative and economically situated so that there will be no burden or worry for other members of the family, may under the strict supervision of the attending physician receive treatment at home. Many otherwise favorable cases do not improve in the sanatorium due to psychologic peculiarities and make better progress when they return to more congenial home surroundings. Individuals of this kind are very familiar to the sanatorium authorities and present, in some cases, serious problems in proper management, especially if the patient is a carrier of tubercle bacilli. If every diagnosed case of tuberculosis, minimal or otherwise, were to be hospitalized, the beds now available for this purpose would fall far short of the number required and the consequent cost to the community would reach a burdensome figure in order to make these facilities possible.

The underlying principle in tuberculosis treatment was rest; the more absolute, the better. No time limit was set as to how long rest should be continued and the results obtained were in direct proportion to the extent of the disease when treatment was begun. If the patient became symptom free, had gained considerably in weight and could tolerate a few hours exercise, he was considered as practically cured. Recurrence in many of these cases was very common. In other words the patient was cured of his symptoms, but not of his tuberculosis. To-day we are seeking for, and achieving, in many cases, a more permanent cure, with restoration of the patient to the community, economically independent and capable of supporting himself and his family. We are striving to

make him a full fledged member of society and not a menacing carrier of tubercle bacilli to be shunned by his associates and family. It is common knowledge that our advice to many of the moderate and advanced cases was to go to bed and wait to see what happens. How uncertain, how hazardous and frequently how discouraging. This attitude of letting nature take its course or that there was little else to be done, gradually became the credo of the physician himself. To tell such a patient the same thing to-day, amounts to an admission that the disease is too far advanced and that recovery is problematical. The change from helplessness to hopefulness has been largely brought about by the enforcement of lung rest through the judicious use of collapse therapy. The surgeon has entered upon the scene and his skill, united with the judgment of the internist, has been productive of such striking results, rarely seen in any other disease. Many otherwise incurable patients with cavity formation and positive sputum have been apparently cured. The best results can only come from close cooperation between the medical man and the surgeon; this relationship must always be maintained. I have noticed that in patients receiving collapse therapy, the well-known optimism of the tuberculous becomes more genuine and is no longer just a mental state tinged with mingled doubts and fears.

Rest, therefore, more broadly applied and more definitely instituted, still remains the keystone of modern treatment. After collapse therapy has been started, bed rest must be enforced for varying periods dependent upon the condition of the pulmonary lesion. For a large number of patients receiving pneumothorax therapy and with a negative sputum, sanatorium residence is considerably shortened. Many of them are able to continue resting at home and receive their refills at regular intervals either at the sanatorium, hospital or privately as the case may be. Not a few of them return to their work and carry on collapse therapy at the same time. Bed rest must be enforced until the lesion becomes quiescent and if they are carriers of tubercle bacilli, every provision must be made to prevent spread of infection to others. This can be accomplished through hospitalization or at home if conditions are such that supervision and enforcement of isolation precautions can be effectively carried out.

Bed rest alone has cured many cases of tuberculosis and will continue to do so. The vast majority of minimal cases get well on bed rest alone. The moderately advanced and advanced cases with cavity formation and positive sputum, present the greatest therapeutic problems and it is in this group that collapse therapy has done so much. We have frequently seen lesions of the exudative type involving an entire lobe heal completely by resolution under bed rest. We have also seen similar lesions go on to excavation and rapid dissemination on bed rest. Cavity formation is a serious handicap for any tuberculous patient. There is the ever present danger of hematogenous or bronchogenic dissemination of the disease and the spread of infection to others. Some cavities heal spontaneously, but in the majority of cases unless compression is applied, serious consequences inevitably follow.

The dietary for the tuberculous patient should be well balanced and overstuffing is best avoided. Three meals a day with nourishment in between is usually sufficient. For intestinal, laryngeal or skin tuberculosis special diets are sometimes necessary.

Much has been said about climate in the treatment of tuberculosis. Good results are reported from widely divergent types of climates so that we have come to look upon climatotherapy as not an absolute necessity in the treatment of tuberculosis. Involving as it does a long residence away from home and a large financial outlay, the majority of patients are unable to bear the strain. A change of scene is good for any chronic invalid provided he is economically able to meet the costs with freedom from mental worry.

Heliotherapy is contraindicated in pulmonary tuberculosis. In certain cases of glandular, bone and joint, skin, intestinal and laryngeal tuberculosis, it has proved of great value.

Chemotherapy in tuberculosis has been tried time and time again. The salts of many of the heavy metals have been used but the results were always found wanting. Just now the thiosulphate of gold, known commercially as sanocrysin, is being used rather extensively; more so in Europe than in the United States. Some of the reports in the foreign literature are very glowing and enthusiastic. However, in this country, a few years ago, sanocrysin was given a most impartial trial and very intensive studies were made with suitable controls. The results were published by Amberson, Pinner and MacMahon in the *American Review of Tuberculosis* for October, 1931, and I shall quote from their conclusions:

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RHODE ISLAND MEDICAL SOCIETY

Meets the first Thursday in September, December, March and June

ALBERT H. MILLER	*President*	Providence
ROLAND HAMMOND	*1st Vice-President*	Providence
JOHN E. DONLEY	*2nd Vice-President*	Providence
J. W. LEECH	*Secretary*	Providence
J. E. MOWRY	*Treasurer*	Providence

DISTRICT SOCIETIES

KENT

Meets the second Thursday in each month

DR. JOHN A. MACK	*President*	West Warwick
DR. L. J. SMITH	*Secretary*	Buttonwoods

NEWPORT

Meets the second Thursday in each month

JOHN RIDLON	*President*	Newport
ALFRED TARTAGLINO	*Secretary*	Newport

PAWTUCKET

Meets the third Thursday in each month excepting July and August

HENRY J. HANLEY	*President*	Pawtucket
THAD A. KROLICKI	*Secretary*	Pawtucket

PROVIDENCE

Meets the first Monday in each month excepting July, August and September

CHARLES F. GORMLY	*President*	Providence
P. P. CHASE	*Secretary*	Providence

WASHINGTON

Meets the second Wednesday in January, April, July and October

E. E. KENYON	*President*	Kingston
JOHN CHAMPLIN, JR.	*Secretary*	Westerly

WOONSOCKET

Meets the second Thursday in each month excepting July and August

W. A. BERNARD	*President*	Woonsocket
T. S. FLYNN	*Secretary*	Woonsocket

R. I. Ophthalmological and Otological Society—2d Thursday—October, December, February, April and Annual at call of President. Dr. Robert C. O'Neil, President; Dr. N. A. Bolotow, Secretary.

The R. I. Medico-Legal Society—Last Thursday—January, April, June and October, Archibald C. Matteson, President; Dr. Jacob S. Kelley, Secretary-Treasurer.

EDITORIALS

TO BE OR NOT TO BE

That is the question. It will be remembered that a few years ago the *New England Journal of Medicine* was founded as a successor to the *Boston Medical and Surgical Journal*. At that time the new publication took over not only the work of its eminent predecessor but also it became the official journal of the State Societies of Vermont and New Hampshire as well as of Massachusetts. Rhode Island was invited to throw in its lots with its sister state societies, accept representation on the staff of the new organization and, of course, discontinue the publication of this JOURNAL. Sentiment for such a move was apparently completely lacking. Due to the splendid efforts of our able administration and business management our JOURNAL had become one of the largest state medical publications in the country and had been able to make substantial contributions to the State Medical Society. The maintenance of traditional Rhode Island independence appeared to have unanimous approval.

Recently a reconsideration of the question has been mentioned in informal conversations which have come to our ears. Under such circumstances the JOURNAL wishes in a spirit of perfect frankness to put the question up to the members of the State Society. If we should act in accordance with the fashion in contemporary medical writing we would probably present in tabular form the arguments, ranged in opposing columns, for or against such an *Anschluss*. In lieu of such a table let us say that in the column labelled "against" we would place the fact of our independence, our JOURNAL entirely under our own control and a ready medium for the detailed publication of medical communications and society proceedings of local origin, which would of necessity be much curtailed in anything but a local Journal. On the other side of the picture it is a fact that the *New England Journal of Medicine* is one of the greatest medical publications in the country, that it is published weekly, and that it would be of tremendous professional value to Rhode Island practitioners. It is clear that there are two sides to the question. In this latter phase we would have to consider the extreme likelihood of paying the *New England Journal of Medicine* four or five hundred dollars a year, of getting only one Journal a month, of the doing away with all of our exchanges, of getting no books for review (that now go to the Library), of having publication of the transactions of our various societies eliminated, of leaving the option of publication of our "papers" and other material to others and finally of becoming merged as another subsidiary of another Journal.

SOCIAL SERVICE

A physician who was always friendly, and glad to aid, in the early days of medical social service, once said: "It is at once the most fascinating and dangerous of the professions." (Our apologies if the quotation is not verbatim. To advise, individually, the method that one should follow, in conducting one's life, certainly is a delicate matter. This, however, is the task that often falls to social workers in general, and more especially to those doing medical social work. Generally speaking, it is well and helpfully done.

The late Sir William Osler in addressing a graduating class of nurses, remarked that it was easy to learn the language of science, inferring of course that the interpretation of science is quite another matter. This is a fault common to medical social service workers. They speak of "Ca," and "P.A.," and "Type I," or "Equino Varus," or "4+" with the ease which one would expect from a doctor qualified to explain every such term. It is a very minor fault but one which causes many physicians to become somewhat hostile. As an assistant to medical men, social workers should avoid this common failing. They should also bear in mind that the medical profession is largely made up of individuals, whose income depends almost entirely upon personal endeavor, whereas they themselves receive a salary from a corporate origin.

During the last two years, while financial conditions have necessitated the granting of aid by local or federal governments, social workers have been more in evidence than ever, and that they have done an excellent piece of work there is no doubt. They have, in general, resisted political interference better than any other group, they have been essentially level-headed and fair in the interpretation of small incomes, and they have taught many families that some, at least, of their misfortunes, have been due to lack of frugal ways. To literally invade a household, investigate its finances, learn of its savings and losses and pass judgment upon the advisability of aid, has been accomplished with the very minimum of ill-will or friction.

The medical social worker has found and developed a very definite field, and physicians who have seen her work realize its value. To those who have felt that she oversteps her bounds, or that she offers unsound advice as to the solution of medico-social problems, let it be said that her profession is still young, and over-zealousness rather than personal gain is the cause. Her presence is almost fatal to the success of a "quack," for she is strong for the ethical physician, is generally well educated and has a generous amount of common sense. We believe the physician who knows little of the medical social worker, will admire her work more and more on better acquaintance.

ARTHRITIS

During the past ten years, an increasing number of papers on arthritis has appeared in the medical literature. Medical conventions have sponsored

symposiums on the subject and arthritic clinics are appearing in one city after another.

Books on arthritis reflect the present-day attitude of those treating the disease,—that of optimism. It is in contrast with the pessimism of the past. The brighter outlook is not an assumed one, for much has been done to arrest and alleviate the suffering that was once considered as a matter of course.

Joints are not permitted to anklyose in faulty positions; muscles are not permitted to become stiff and atrophic. The general system is put into good physiological shape. The mind is kept hopeful and cheerful; pain is treated, and sleep promoted.

Each year sees a larger number of patients completely recovered, and a still greater number returned to usefulness with only slight or inconsequential deformities. Most encouraging is the very active interest on the part of the profession, for it presages added information about arthritis.

SOME MEDICAL ASPECTS IN THE TREATMENT OF PULMONARY TUBERCULOSIS

(*Continued from page 150*)

"We discovered no evidence in 12 cases that sanocrysin given in small, gradually increasing doses up to a total of 6.1 gm. has a beneficial effect on pulmonary tuberculosis or its complications.

"Compared with control cases more of our sanocrysin treated cases became worse.

"Sanocrysin exerted definitely harmful systemic effects in all our treated cases partly as a secondary result of its action on the local tuberculous lesions but mostly, we believe, by virtue of its own inherent toxicity. These effects were usually on the nutrition, gastro-intestinal function, temperature, mucous membranes and kidneys.

"One sanocrysin treated patient died from parenchymatous degeneration of the liver and other effects which we interpret as gold poisoning.

"Because of the lack of definite evidence of benefit and because of positive evidence of harm which in some respects is long lasting, especially in the kidneys, the use of sanocrysin as we used it is not justified."

Various other methods of treatment have been reported and are still in use but their results are so debatable that final discussion is better postponed.

A tremendous amount of work is being done in the prophylaxis of tuberculosis and although disagreement exists as to many details, the consensus of opinion is that it provides our only means for the prevention of infection and disease and its recognition in the earliest stages. It is our duty to see to it that every individual exposed to tuberculosis is examined periodically because, the carrier of tubercle bacilli as long as he remains unaware of his condition, is the fertile source of infection for potential new cases. The carrier may be anywhere, in the home, schools, colleges, medical schools, hospitals, or workshops; in fact, wherever large groups congregate continuously or repeatedly. Knowing this, these examinations are being made throughout the world among known family contacts, school children, college students, interns, nurses, foodhandlers and many others. In some European universities, no student is admitted without previous X-ray of the chest and physical examination. In this way many positive cases have been found which would have been overlooked.

The conduct of these examinations is well within the scope of the private physician and it is within his power to acquaint himself with the procedures involved and in this way do his part in a work which will make but slow progress without him.

OBITUARY

JEFFREY JAMES WALSH, M.D.

Born in Fall River, Mass., Sept. 23, 1883, died after a brief illness of ten days of lobar pneumonia.

His preliminary education was obtained in his native city. His wish to become a pharmacist was early realized. His assiduous devotion to his chosen field of endeavor supplemented by his native thrift and business acumen was soon rewarded with complete success and fired his ambition to climb to greater heights.

He matriculated at Tufts Dental School and commuted to Boston while still conducting his pharmacy in Fall River and received his D.D.S. in 1910. After a few years at his new profession, still imbued with a desire to climb higher, he re-entered his Alma Mater and was awarded the degree of M.D. in 1918. A post-graduate course in the Eye, Ear, Nose and Throat department of the Boston

City Hospital completed his studies and started him on a successful career of specialization.

He came to Providence in 1920 and opened an office on Broad Street. He at once contacted with the R. I. Hospital, St. Joseph's Hospital, the Charles V. Chapin Hospital, the Miriam Hospital, Homeopathic Hospital, all of Providence; the Pawtucket Memorial and the State Infirmary. He became a member of the Providence Medical Association, the R. I. Medical Society, the R. I. Otological and Ophthalmological Society, the last of which he had represented as President and Secretary.

He again showed his interest in dentistry by membership in the R. I. Dental Society and at the time of his death was president of the local chapter of Tufts Alumni. He held a Fellowship in the American College of Surgeons since 1932.

On September 29, 1928, he married Mary M., daughter of Dr. and Mrs. John T. Ward. He served well for two years in the City Council of his adopted city, and while a member of the latter body was elected a member of the Board of Hospital Commissioners, acting as secretary for two years.

"Jeff," as he was familiarly known among his intimate friends, was very fond of swimming and rarely missed an opportunity to take in an intercollegiate football contest. He was genial and modest by nature, enjoyed and enlivened his associates by his youthful exuberance and always took a major part in entertainment.

In his professional work he was serious, practical, studious, conscientious, skillful, keen for work as exemplified by his numerous hospital affiliations. He entertained the highest ideals and stimulated the same in all those who were privileged to know him.

His friends extend to the bereaved family their keen sense of loss in the sudden passing of Dr. Jeffrey J. Walsh.

(Signed) EDWARD A. MCLAUGHLIN

ROBERT CONNERY O'NEIL
1899-1934

Dr. Robert Connery O'Neil died March 21, 1934, at his home in Warren, Rhode Island, from pneumonia of a few days' duration.

Born May 25, 1899, in Warren, Rhode Island, the son of Patrick W. and Margaret Connery O'Neil, he received his early education in the public schools of Warren, later attending and graduating from La Salle Academy in this city. His collegiate work was done at Catholic University and Georgetown University in Washington, D. C. In 1925 he graduated from the Medical College of Virginia in Richmond, being president of his class. After internships at the Rhode Island Hospital and the Charles V. Chapin Hospital he became a house officer at the Massachusetts Eye and Ear Infirmary on the Ear, Nose, and Throat service. Upon completion of his training in Boston he opened an office in this city, confining his practice to ear, nose, and throat work.

Dr. O'Neil was a member of the Providence Medical Association, the Rhode Island Medical Society, the American Medical Association, and was president of the Rhode Island Ophthalmological and Otological Society.

He was on the active staffs of the Rhode Island Hospital, the Charles V. Chapin Hospital, St. Joseph's Hospital, the Pawtucket Memorial Hospital and on the courtesy staff of the Homeopathic Hospital; at the State Institutions he was consulting otolaryngologist.

Notwithstanding the short time that he was in active practice his affable nature, good fellowship, and hearty laugh made a lasting impression and he will long be missed by his colleagues, friends, and the many patients in a practice which was growing rapidly.

Respectfully submitted,
RAYMOND F. HACKING, M.D.
JAMES H. FAGAN, M.D.

THOMAS EDWARD DUFFEE, M.D.

Thomas Edward Duffee was born in Hillsboro, New Hampshire, in 1872. He attended the common schools of Hillsboro, the high school at Warren, New Hampshire, and Tufts Academy. He graduated from the University of Vermont in 1903 with the degree of Doctor of Medicine. After graduation from medical school, he practised for several years in Winchenden and East Bridgewater, Massachusetts. He then went to New York, where he spent a year taking post-graduate courses in diseases of the eye, ear, nose and throat. At the end of that time, he went to Gardner, Massachusetts, where he practised several years as a specialist in diseases of the eye, ear, nose and throat.

In 1912, he sold out his practice and took postgraduate courses in his specialty in New York and Philadelphia. He then opened an office in Pawtucket and was appointed chief of the Eye, Ear, Nose and Throat department of the Memorial Hospital, Pawtucket, R. I. He was also connected with the Eye, Ear, Nose and Throat department at the Rhode Island Hospital from April, 1915, to February, 1922. He practised his specialty in Pawtucket and Providence from 1913 to 1932.

He resigned from the Memorial Hospital Staff, January 1, 1928, and was appointed to the Consulting Staff. In 1932, he opened an office in Wakefield, Rhode Island, and lived at Tower Hill up to the time of his death, which occurred at the Wakefield Hospital on November 10, 1933, from a complication of diseases.

Dr. Duffee was a thirty-second degree Mason. He was a member of the Artisan Lodge of Winchenden, Massachusetts, a Knights Templar and a member of the Rhode Island Consistory. He was also a member of the Palestine Temple, Order of the Mystic Shrine.

His clubs were the Wannamoisett Country Club and the University Club of Providence.

He was a successful practitioner in his specialty of the eye, ear, nose and throat in Pawtucket and Providence for twenty years. He was a member of the Providence Medical Association, the R. I. Medical Society and the American Medical Association.

He was married in 1914 to Emogene L. Menzel, who with one daughter, Jane Elizabeth Duffee, survive him.

HENRY W. HOPKINS, M.D.
CHARLES O. COOKE, M.D.

Joel Audubon Webb, M.D., was born in Perryville, South Kingstown, R. I., July 16, 1854, the son of Stanley W. and Rebecca Ann (Hazard) Webb.

He was educated in the public schools, and at Highland Military Academy, Worcester, Mass. He taught school and afterward studied in the office of his preceptor, George F. Keene, M.D., also of fragrant memory.

He was graduated from the medical department of New York University in 1889. He had lived at intervals in Plainfield, Conn., Norwich, Conn., and, in the main, Providence, R. I.

He practised medicine only a short time. For many years he was on the staff of Sampson & Murdock Company, publishers of the Providence Directory.

Dr. Webb never married.

He was an attentive and interested listener to our scientific programs. Constant, faithful, he seldom missed a meeting of this society.

He died in Providence, R. I., February 20, 1934.

Respectfully submitted,

J. E. MOWRY

SOCIETIES

PROVIDENCE MEDICAL ASSOCIATION

The regular monthly meeting of the Providence Medical Association was called to order by the president, Dr. Charles F. Gormly, Monday evening, April 2, 1934, at 8:45 o'clock. The records of the last meeting were read and approved. Dr. Jesse E. Mowry read an obituary on Dr. Joel Webb and Dr. Edward A. McLaughlin read one on Dr. Jeffrey J. Walsh. It was voted to spread these on the records, print them in the JOURNAL and send copies to the families.

Dr. James F. Boyd reported two cases of superior pulmonary sulcus tumors with X-ray films. These were discussed by Dr. Edward S. Cameron.

Dr. James F. Hawkins reported a case of adenoma from the naso pharynx.

Dr. Peter Pineo Chase read the first paper of the evening on "Cancer of the Mouth." Cancers of the lower lip were considered separately from those of the buccal mucous membrane being generally less serious. They can be treated by excision or radiation and in properly selected cases the upper neck is dissected. In both situations irritation appears to be a predisposing factor. Biopsies are very important. Inside the mouth radiation is more used although surgery is not excluded. Mouth hygiene is important. Quick decision and vigorous action is the watchword. Discussion was by Drs. Clarke, Gerber and Oddo.

Dr. Lucius C. Kingman reported for the Public Relations Committee that the school department had consulted them regarding a physical examination of children before entering school. The committee thought the idea good but felt that wherever possible these examinations should be done by fam-

ily physicians with a follow-up by public health nurses. The report was discussed by Drs. J. Kelley, Skelton and Kingman, was accepted. The secretary instructed to forward a copy to the Superintendent of Schools.

The second paper was by Charles J. Smith, D.M.D., "A Consideration of Some Diseases of the Jaw." He laid stress on osteomyelitis, which is rare in the upper jaw but common in the lower and felt the medical men and dentists should work together on this. Pain, fever and trismus after extraction are very suggestive but X-rays may be negative in early cases and should be repeated. Drainage is important. These infections are usually in the molar and bicuspid regions. He also discussed cysts and various tumors, all requiring surgery. The paper was illustrated by numerous interesting slides and a case report where an entire lower jaw was removed as a sequestrum.

The meeting adjourned at 10:50 P. M. Attendance, 109. Collation followed.

Respectfully submitted,

PETER PINEO CHASE, *Secretary*

The regular monthly meeting of the Providence Medical Association was called to order by the president, Dr. Charles F. Gormly, Monday evening, May 7, 1934, at 9:50 o'clock. The records of the last meeting were read and approved.

Dr. Charles O. Cooke read an obituary on Dr. T. E. Duffee and Dr. Raymond F. Hacking read one on Dr. Robert C. O'Neil. It was voted to spread these on the records, send a copy to the family and one to the medical journal.

Drs. Kenneth G. Buxton and Louis A. Normandin were elected to membership.

A letter was read suggesting a Providence Medical Association golf tournament. On the motion of Dr. Charles O. Cooke the president was empowered to appoint a committee of five to organize such a tournament and the appropriation of the necessary money was referred to the Standing Committee.

Dr. Milton C. Goldberger read the first paper on Sterility; the investigations and findings in 24 cases. Usually no single factor is held responsible but there may be a threshold of conception which is not reached and a question of relative sterility. He discussed the factors involved and the methods of investigation. In 47% of the cases the males were apparently partly responsible and in 26% the females were absolutely sterile. Drs. Ira Noyes and Pitts discussed the paper.

Dr. Thomas R. Goethals of the Harvard Medical School and Boston Lying-In Hospital read the second paper on "The Risk to the Infant in Breech Delivery." This was a statistical paper analyzing 1,059 breech deliveries in a total of 26,420 and bore out the generally accepted impression that such deliveries are much more dangerous to the baby than vertex. Drs. Walsh and Brackett discussed the paper.

Dr. G. Elliott May of Boston City Hospital and Harvard Medical School read a paper on "Dehydration Therapy in the Toxemias of Pregnancy." The etiology of these cases is still not known but they presumably are not a kidney problem. As hydrated animals tend to convulsions and the brain of eclamptics is found edematous and 8-10 ounces of concentrated urine is found sufficient to take care of the body needs, they dehydrate toxemic patients by giving them magnesium sulphate and a glass less of fluid daily than the previous day's output of urine. In a small number of cases thus far treated the results are encouraging. The paper was discussed by Drs. Brackett, Buxton, Partridge, Hale and Appleton.

The meeting adjourned at 10:45 P. M. Attendance, 112. Collation was served.

Respectfully submitted,

PETER PINEO CHASE, *Secretary*

PAWTUCKET MEDICAL SOCIETY

The House of Delegates at its annual meeting approved and adopted the report of its committees on Public Health Clinics. The salient parts of this report are as follows:

1. The co-operation of medical and lay societies is recognized as often being expeditious and beneficial; but the lay sponsoring of clinics should not be tolerated except in co-operation with local society or hospital.

2. Grievance committees of local physicians should be formed to iron out difficulties with related social and welfare agencies in communities where such committees do not now exist.

3. All clinics of whatever nature be operated only by local hospital or by special approval of local medical society.

4. It is considered unethical for full-time Federal, State or Municipal physicians to engage in any form of private practise.

5. All clinics to be operated for the INDIGENT only and a determined and searching inquiry to be made as to the actual financial condition of all patients before their admission to the clinics.

6. Oppose the practise of State Welfare nurses visiting post-natal cases of private physicians. Activities of the nurses should be restricted to the indigent.

7. District nurses should not do blood pressure or urine examinations on pre-natal cases. Physicians should do their own work and not expect the nurse to do it for them.

8. Nurses should not refer patients to a tonsil clinic directly. All suspected tonsil and adenoid cases to be first referred to the family physician. If patient has no regular family physician they should select one.

9. Oppose the operation of K L immunization clinics and child welfare clinics except for the indigent.

10. Oppose operation of pre-school clinics, but sponsor the pre-school examination by family physician.

11. Favor the adoption of school department regulation requiring K L immunization as well as vaccination before admittance to school.

This committee has been authorized to contact the various medical, social and welfare agencies with a view to obtaining their co-operation in this program.

It is eventually hoped that the co-operation of every member of the medical fraternity in Rhode Island will be obtained.

Now that the State Society has taken a definite stand in these matters it behooves every physician to decline to serve on clinics not approved of and to refuse to do pre-school clinics with the assurance that everyone else will do likewise.

When a lay or nursing organization plans to operate any welfare project it should apply to the district society and if approved, the district society should assign its members to serve in rotation unless the society agrees to a permanent appointee. In any event the organization sponsoring the welfare project should apply to the District Society and not to the individual physician. All physicians approached to serve on such projects should first consult the District Society before accepting any appointments.

Within a few months each district society will have an opportunity to consider the desirability of the various clinics in their locality and to state ther attitude toward them.

This committee is ready to aid in every way in bringing harmony out of discord and welcomes suggestions and reports from all sources.

As a separate but vital part of the committee's program is a plan for post-graduate instructions for members of the State Society. If it is found to be possible lectures will be held, demonstrations given and courses arranged to present new methods of diagnosis and treatment. Radio talks, lectures to the general public, and newspaper advertisements marked "Approved by Rhode Island Medical Society" will be used in an effort to make the general public conscious of medical services. This is in line with similar approved practises elsewhere.

Many other phases of the program remain undecided at present, but one definite object is to make the Rhode Island Medical Society the voice and the regulating medium of the physicians of this State. It is proposed to have the Society speak authoritatively on medical practise and to exert itself to the utmost for the welfare of its individual members, so that membership in the Society is a desirable and profitable thing.

A campaign for membership is being waged and you are asked to personally canvass those members of your district Society who have never joined the State Society in an effort to enroll them as new members. A check for $10.00 made out to the Rhode Island Medical Society should be mailed to Dr. J. W. Leech, Secretary, for each new applicant.

A member of this committee will call on each society in the Fall to further and more directly acquaint them with our plans and the results of our efforts.

The socialization of the practise of medicine is well within the realm of probability and only by prompt and decisive action now can we avoid such a catastrophe in Rhode Island.

Your earnest co-operation will be appreciated.

CHARLES L. FARRELL, M.D.

RHODE ISLAND MEDICAL SOCIETY
ANNUAL MEETING

REPORTS OF COMMITTEES

(Continued from the August Journal)

ANNUAL REPORT OF COMMITTEE ON PUBLIC HEALTH CLINICS

The Committee on Public Health Clinics submits its first preliminary report.

The report is divided into three sections:—

Section 1. consists of the more important information placed before the committee by individual physicians, members of the Medical Societies of Woonsocket, Pawtucket and Newport, the grievance committee of the Kent County Medical Society and it deals with the activities of State operated clinics—Well Baby Clinics, Part Pay Clinics, Nursing Association Clinics, Pre-School Clinics and Immunization Clinics.

Section 2. embodies the recommendations of the committee as a result of its review of the material in Section 1.

Section 3. recognizes the trend toward "state medicine" or rather the "socialization of medicine" and suggests possible courses of action open to this society.

Section 1.

1. As regards the Mental Hygiene Clinics in Woonsocket your committee finds that Woonsocket physicians object to the operation of a Mental Hygiene Clinic by state paid physicians, under lay auspices, as at present; but are willing and anxious to operate such a clinic in the hospital or by themselves with co-operation of state physicians when and if needed.

2. In Newport the Mental Hygiene Clinic is operated under lay auspices by a private physician and is not located in nor connected with the hospital. The operation of this clinic in this manner is objected to, but the hospital staff is anxious to have such a clinic in the hospital under direction of the hospital staff with the co-operation of state physicians when and if needed.

3. Woonsocket physicians are evidently unable to obtain the proper degree of co-operation with the District Nursing Association and have withdrawn their medical representative from the board of directors.

4. The clinics for tuberculosis are held at the Woonsocket Hospital, the Pawtucket Red Cross and Newport Hospital, but are operated by state paid physicians. The instructions sent to the Pawtucket Clinic, copies of which were given the committee, are so drawn as to permit the admission to the clinic of almost anyone at anytime whether able to pay a physician or not, and the report for the year 1933 shows 312 new cases, of which, only 32 were referred by physicians—5 from hospitals and 14 from such sources as Department of Public Aid, S. P. Cruelty to Children, Mother's Aid, Associated Charities, etc., who were evidently in a position to know the financial status of the patients—while 211 cases were referred by Red Cross Nurses. It is evident that the zealousness of Red Cross Nurses is for record attendance and the *Clinic* rather than the *local physician* is paramount.

There seems to be no check on the ability of a patient to pay, and it has been reported that patients well able to pay are treated at the tuberculosis clinic. In one instance where a patient was discharged to a private physician he returned because of political influence. The contacts of a tuberculosis case should be examined by the family physician, but often the contacts get to the clinics without knowledge of the physician. These contacts are examined and X-rayed at the State's expense. On instructions from Dr. Barnes the clinic (state) physician may not examine a patient who is able to pay a specialist, at the clinic, but he may see him at his home and collect a fee for such an examination after the clinic is over. Nurses may bring, as a patient to the clinic, any person who is reluctant to go to a doctor.

It is also claimed that many cases are admitted and sent to Wallum Lake who are not tubercular; also that X-ray work is done for reduced or nominal fees.

5. The state operates Child Welfare Clinics; Pawtucket and Newport operated Well Baby Clinics where babies are weighed and examined—formulas changed and advice given to mothers. There seems to be no check on the ability to pay, as mothers who were delivered as private patients, are attending these clinics.

6. State Welfare nurses call on patients discharged from maternity hospitals even though they are private patients and without the knowledge or consent of the physician in charge.

7. District nurses have on occasions taken blood pressures and examined urine on pre-natal cases and have made calls without request of the physician.

8. Evidence was presented that an insurance company official made "nursing care" an issue in his drive for more business and urged his agents to employ it as much as possible.

9. Nurses have reported, as Scarlet Fever, cases where the physician in charge had not decided as to the diagnosis, and while waiting for 24 hours to elapse found the house placarded.

10. Nurses have been engaged in examining throats and deciding on the advisability of tonsillectomy—then referring the patient to Part Pay Clinics for operation instead of first referring them to their family physician. Two such clinics were reported.

11. Nurses in Woonsocket have also referred cases for tonsillectomy without being seen by a physician and operation has many times been refused by city physicians.

12. The operation of clinics for the immunization against Diphtheria by State Welfare Nursing Association or other auspices without regard to the need for free services is claimed to be detrimental to the interests of the private practitioner.

13. The operation of Pre-School Clinics, using private practitioners at no salary, do work which is in the province of the family physician. This work is often undertaken reluctantly by the physician asked to attend, but they accept because the custom is general and there is no record of the attitude of this society regarding this work.

14. As an instance of the operation of free Diphtheria immunization clinic—a person who runs a private kindergarten attended by children whose parents are well able to pay a physician, took her charges to the State Clinic and had them all immunized against Diphtheria.

15. Persons are circularized to take their children to clinics for immunization. Clinics have a way of advertising—physicians do not. Literature sent out from Child Welfare Bureau and distributed by state nurses, urges parents to bring children to a free clinic at the State Office Building for immunization.

Section 2.

After due consideration of the material in Section 1 your committee makes the following specific recommendations:—

1. The co-operation of medical and lay societies is recognized as often being expeditious and beneficial; but the lay sponsoring of clinics should not be tolerated except in co-operation with the local Medical Society or hospital.

2. We suggest the formation of a committee of physicians of the Woonsocket Medical Society to act as a grievance committee whose functions will be to iron out difficulties with District Nursing Associations. It is felt that if District Nursing Association Directors can be shown the medical aspect, and the physicians shown the District Nursing Association aspect—a solution to all difficulties will be speedily forthcoming. Such a system works well in Pawtucket.

3. Recognize the principle that *all* clinics of whatever nature be operated only by the local hospital or by special approval of the local Medical Society.

4. Establish Tuberculosis and Mental Clinics in local hospitals with local physicians on the staff if desired by them.

5. Consider it unethical for State, City or Federal full time physicians to engage in private practise.

6. Oppose the operation of State Clinics unless requested by the local Medical Society. In communities where facilities for such clinics under hospital auspices are limited or impossible the location of the clinic should meet the approval of the Medical Society.

7. Oppose the practice of all hospitals in doing X-ray work on ambulant patients not admitted to hospitals or Out-Patient as regular ward or clinic cases.

8. Child Welfare Clinics in general do good work, except that there is a tendency on the part of some physicians in attendance to make radical changes in formulas, and while not actually treating patients with medicine, instances are recalled where definitely mal-nourished and eczematous infants were not referred to a private physician but kept on at a clinic on formula changes. The "ability to pay" should be the criterion for admission to all at these clinics.

9. State Welfare Nurses are furnished with a list of discharged maternity cases, and they call on them without knowledge of the physician and give advice. Your committee suggests that the State Society arrange with the Welfare Commission to limit the activities of its nurses to the indigent and reiterate the principle that ABILITY to pay be the criterion of public welfare service everywhere.

10. The State Society should make representations to the Providence District Nurses Association regarding co-operation along the usual lines—stressing the fact that nurses should not take blood pressures, do urine examinations nor diagnose contagious diseases when there is a physician on the case.

11. It is further suggested, in regard to nurses in private homes, that the following principle be agreed upon and adhered to:—i.e., It is unethical for a nurse to visit the private patient of any physician while he is in attendance on the case except when requested to do so by the physician or by the family themselves. In many instances neighbors and insurance agents have wasted many nursing hours by sending nurses to homes where they were neither needed nor desired by the family or the physician. The State Society could clarify the situation by enlisting officially the co-operation of the insurance companies in not sending nurses without first consulting the physician in charge.

12. The State Society seek further co-operation with District Nursing Associations in regards to tonsil refers. It should be repeated that in cases of suspected tonsil infections all patients be referred first to the family physician before arrangements are made for operation.

13. Your committee is fully sensible of the splendid showing our state has made in Diphtheria records and appreciate the necessity for Diphtheria immunization work, but it is reminded that we also have a splendid record as regards smallpox because of compulsory vaccination before admittance to school. It is suggested that the State Society assume an active part in the establishment of school department regulations which would make Diphtheria immunization necessary for admission to school. The committee also recommends that the immunization work be done largely by private practitioners and the state or other Welfare clinics be conducted, as always, for the *indigent* only.

14. State Society to go on record as opposed to the operation of the so-called "Pre-School Clinics" but sponsor the Pre-School examination by the family physician, and the examination of the indigent Pre-School child at established Child Welfare Clinics.

Section 3.

The socialization of the practise of medicine is well within the realm of probability, and we find many articles in the public press to support such a contention. Government agencies are assuming more of the responsibilities of maintaining the public health. This is due in a large measure to the indifference on the part of most physicians to the field of preventative medicine. To quote from the report of the Michigan Survey of Medical Services and Health Agencies: "Involved in the picture is the finding that the public does not seek nor does the average physician report anything but a meager practise in the field of preventative medicine." "Effective preventative medicine (Public Health Work) depends on the co-operation of Public Health officers and individual physicians in joint participation." "Do away with health clinics and return the patient to the doctor;" "interest the profession in economic problems;" "economics is the science that deals with the material means of satisfying human desires. The health desires of the public will be satisfied when we of the medical profession reflect the material means of individual proficiency, combined with public consciousness and the public recognizes *its* obligation to share in the burden of providing adequate medical care for the body politic."

Dr. W. W. Bauer, director of Bureau of Health and Public Instruction of the A. M. A., says—regarding community responsibility of the health of the individual—"There is, of course, no disagreement about such community measures applicable en masse, as the purification of water supplies or the inspection of meat, milk and perishable foods, nor is the necessity for health education in the schools and by health departments questioned. These are plainly outside the province of individual effort, and must be done by the community—also they are outside the domain of health nursing. It happens that most of the Public Health activities on which there has been disagreement have been those in which Public Health nurses necessarily play a large part. Particularly in the field of infant health, and more lately in connection with pre-natal programs and pre-school project as well as immunizations, differences have arisen as to how far the community may go with propriety in promoting health of individuals without considering the financial ability of the persons concerned." "All successful Public Health Clinics reduce the market for medical services;" "The traditional reserve of the medical profession and its ethical objection to permonal exploitation have caused it to permit the initiative in many health programs to pass to other hands perhaps not for the best interests of the community." An article in a weekly magazine recently held that medical care was a social right, ridiculed the code of ethics and raised the question as to how long the doctor would continue in the role of an individual *"business"* man. As evidence of changing times, Detroit pays private physicians for doing in their own offices services ordinarily performed by salaried health department physicians. Cali-

fornia has a law to regulate clinics. In Indiana the State Medical Association reorganized the State Health Department and dismissed physicians who did Well Baby demonstrations and mothers classes throughout the state because of competition with private physicians. The New York State Medical Society sponsored a bill in last year's legislature which would curtail or close clinics who were caring for patients able to pay private physicians.

Thus we see the trend of the times in other communities and the reactions to such trends. In Rhode Island we have as yet no need for drastic measures. Our abuses are not great and should easily be remedied by timely and forceful action of the part of this society with out legislative measures except as a last resort. The Rhode Island Medical Society should adopt a militant attitude regarding the trend to State Medicine and should assume the leadership in promoting the welfare of its individual members and safeguard their rights to private practise. This could be done by definite committee contacts with all related social, medical and welfare agencies with a view to clarification of their several aims and a limitation of their operations to avoid conflict and the duplication of effort. Another committee could direct the attention of the members to the field of preventative medicine—urging and aiding their co-operation by lectures and various post-graduate instruction classes as is done in many other states. Still another phase of State Society activity should be the placing of informative advertisements in the public press marked with the endorsement of the Rhode Island Medical Society. This work could be extended to include the distribution to individual members of printed forms bearing State Society endorsement, but minus the physicians name, to be included in the monthly bills of patients urging them to take cognizance of preventative medical services. Such is the ethical practise in Philadelphia. An active campaign should be waged by radio talks and public lectures in an effort to promote public consciousness of medical services. In Michigan 400 physician speakers talk at luncheon clubs and welfare organizations. The Rhode Island Medical Society should be the voice and the regulating medium of the physicians of this state. It should speak clearly, positively and often. Its action shoud be decisive and prompt for the welfare of its members.

We urge an immediate attempt be made to bring within the society all physicians in Rhode Island who are eligible and who for one reason or another have never joined. These men should feel that this is their society and that by supporting it they are furthering their own interests and that they will receive definite benefits from membership in it. The State Society should be more than a body before whom papers are read. Its committees should be clothed with sufficient authority and given sufficient funds for action. If revenues at present are not great enough, new sources should be found by new members or by increased assessment, which would be forthcoming right enough if members were assured of positive benefits thereby. The committee suggests that this committee be increased to five members and that its authority be extended to contact the Social Welfare, Medical and Nursing agencies, with the view to obtaining their co-operation in correcting abuses and to arrive at a proper understanding with them.

(It was voted that the Committee on Health Clinics be continued and be enlarged by the addition of Doctors N. Garrison of Woonsocket, and J. F. Archambault of W. Warwick.)

CHAS. L. FARRELL, M.D., *Chairman*
HARVEY B. SANBORN, M.D.
CECIL C. DUSTIN, M.D.

NEW ENGLAND MEDICAL COUNCIL

Dr. J. A. Chase reported that the Executive Committee of the Council did not feel that any change should be made at this time with reference to the allocation of the share of expenses to the different State Societies. He further reported that the meetings of the Council had been temporarily discontinued.

New Business

The following resolution in regard to Radio Broadcasting was adopted:
Resolved,—

That the Rhode Island Medical Society is opposed to the advertising over the radio of medicines or appliances for the treatment of human ailments and that a copy of this resolution be sent to the Federal Radio Commission with the request that in the interest of the health of the citizens of the U. S. the said Commission exercise their authority to discontinue such advertising on the radio.

On motion made and seconded, it was voted that a committee to be known as a Committee on Cancer be appointed by the President, and the President appointed the following men:
Dr. Herman Pitts, Chairman, Providence, Dr. B. Earl Clarke, Providence; Dr. Geo. Waterman, Secretary, Providence; Dr. I. Gerber, Providence; Dr. J. C. O'Connell, Providence; Dr. P. P. Chase, Providence; Dr. John Kenney, Pawtucket; Dr. C. S. Christie, (Kent Co.), W. Warwick; Dr. W. Rocheleau, Woonsocket; Dr. M. H. Sullivan, Newport; Dr. John Champlin, Jr., (Washington Co.), Westerly.

The following communication from the R. I. Public Health Commission was read by the Secretary.

R. I. PUBLIC HEALTH COMMISSION
Providence, R. I., May 18, 1934

"Dear Dr. Leech,—

By direction of the Rhode Island Public Health Commission, I am writing the secretaries of all the state organizations of practitioners of the healing arts relative to certain contemplated changes in

laboratory work carried on by the laboratories of the Public Health Commission.

Owing to a marked increase in the number of specimens submitted to our laboratories during the past three years, it became necessary to discontinue certain types of work about a year ago. During the past year, however, the number of specimens submitted has increased until at present the amount of work submitted is far in excess of the ability of the laboratory personnel to handle without putting in many hours overtime nearly every night. It is not unusual to find three or four men working until after midnight several nights each week to keep up with the work.

We tried to secure additional appropriations in the regular appropriation bill and later by special resolution, but were unsuccessful in both.

The work of the Laboratories of Pathology and Bacteriology is divided into six major divisions as follows:

1. Bacteriological examinations to assist in diagnosing infectious diseases.
2. Serological examinations in suspected cases of syphilis, typhoid and undulant fever.
3. Microscopic examination of tissue removed at operations or at autopsies.
4. Toxicological, pathological and microscopic examinations to assist medical examiners and police officials in solving known or suspected crimes.
5. Chemical blood examinations.
6. Chemical and microscopic urine analyses.

In view of the fact that with our present limited personnel it is impossible for our laboratories to handle all the work submitted without requiring a large percentage of the personnel to work nights, the Public Health Commission has for several months given serious consideration to curtailment or elimination of services rendered and has decided that the discontinuation of urine analysis is that part of the work the elimination of which would least embarrass the physicians and which would work out to the least disadvantage to the public as a whole.

The Public Health Commission is considering seriously the discontinuation of urine analysis on June 30th of this year and suggests that you present this matter to your society at its next regular meeting to determine whether there is on the part of your society any serious objection to this contemplated action by the Commission. Trusting that your society will approve this Commission's contemplated action in this matter, I am

Very truly yours,

LESTER A. ROUND, PH.D.,
Director of Public Health."

and the following resolution was adopted:

"Resolved,—That the Rhode Island Medical Society, while regretting that the Rhode Island Health Commission finds it necessary to curtail certain of its services to physicians, nevertheless, is in agreement with the Rhode Island Public Health Commission that the elimination of routine urine analyses will result in the least hardship to the physicians and patients, and urges that the Fellows of the Rhode Island Medical Society cooperate with the Rhode Island Health Commission by limiting requests for services to such cases as in their opinion actually require such services for the proper conduct of the case."

On motion made and seconded it was voted that the President appoint a committee of three to consider changes in the By-Laws relative to the meetings of the Rhode Island Medical Society, and the President appointed the following doctors: Dr. A. T. Jones, Dr. C. F. Gormly, Dr. N. Garrison.

Respectfully submitted,

J. W. LEECH, M.D.,
Secretary.

May 24, 1934

IMPORTANT NOTICE

The following letter from the Department of Commerce at Washington, D. C., has been received by the Secretary of the Rhode Island Medical Society.

DEPARTMENT OF COMMERCE

Bureau of Foreign and Domestic Commerce
Washington

June 22, 1934.

Dr. J. W. Leech, Secretary,
Rhode Island Medical Society,
167 Angell Street,
Providence, Rhode Island.

Dear Sir:

In connection with our report to the United States Senate on National Income 1929-1932, we sent out to physicians and surgeons several thousand questionnaires, for anonymous return, and thus collected from every section of the country a fair sample of data on which to estimate total income from practice in the medical profession. Our report was printed as Senate Document 124, and a brief summary is enclosed.

The average net income from practice (tabulated in our report in Table 181 as "per capita income withdrawn") for the years 1929 through 1932 is shown below; it is the result of our survey by questionnaire:

1929	$5,602	1931	$4,544
1930	5,307	1932	3,442

We are now preparing a report, for release this fall, of national income in 1933, and while it is not feasible at this time to gather new data by the questionnaire method, a reasonable figure could be arrived at by using the trend of average income furnished by the Medical Association of each State.

(*Continued on page XVIII*)